TMF
Health Quality Institute

Bridgepoint I, Suite 300
5918 West Courtyard Drive • Austin, TX 78730-5036
Phone 512-329-6610 • Fax 1-800-725-8293 • www.tmf.org

Notice of Independent Review Decision

DATE OF REVIEW: 08/06/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Repeat lumbar CT scan 72131

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The TMF physician reviewer is a board certified neurosurgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the repeat lumbar CT scan 72131 is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
- Information for requesting a review by an IRO – 07/27/12
- Notification of Adverse Determination by Coventry – 06/18/12,
- Decision letter from Texas Mutual - 06/28/12
- Letter to TMF from Texas Mutual – 07/30/12
- Operative Report by Dr.– 01/03/07
- Operative Report by Dr.– 08/21/09
- Report of lumbar myelogram – 04/29/08
- Report of CT evaluation of the lumbar spine – 02/09/11
- Report of post myelogram CT evaluation – 03/23/12
- Report of lumbar myelogram – 03/23/12
- Letters from Dr. to Dr.– 02/14/11 to 06/11/12
- Report of Medical Evaluation by Dr.– 09/27/07

- Response letter from Texas Mutual– 07/30/12
- Portion of the ODG Treatment/Duration Guidelines for Low Back – Lumbar & Thoracic (Acute & Chronic) – 06/29/12

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he was bending and twisting while looking into a furnace. This resulted in injury to his lower back. He has been treated with medications, spinal injections, surgery, physical therapy and the use of a spinal cord stimulator. The patient continues to complain of chronic back pain and there is a request for the patient to undergo a repeat lumbar CT scan.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The medical record documentation does not substantiate the necessity for a CT scan to be repeated. The office note of 06/11/12 indicates that the study is requested "to try something different". The myelogram/CT study of 03/23/12 plus the clinical course outlined in the medical record are satisfactory to discern a suitable course of treatment. Surgery at L3-4 as has already been requested by the surgeon.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**